PRINTED: 02/09/2010 FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN168AGC** 12/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 975 CORDONE AVE **FAMILY HOME CARE RHL RENO. NV 89502** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** Surveyor: 28384 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal. state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 12/16/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for nine Residential Facility for Group beds for elderly and disabled persons. Category II residents. The census at the time of the survey was six. Six resident files were reviewed and no employee files were reviewed. Complaint #NV00023779 was substantiated. See Tag Y879. Y 879 Y 879 449.2742(6)(a)(2) Medication / Change order SS=G NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

administration of the medication shall:

(a) The caregiver responsible for assisting in the

(2) Indicate on the container of the medication

administered to a resident:

that a change has occurred.

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over-the-counter medication or dietary

(a) Plainly labeled as to its contents, the name of

supplement, must be:

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by:

Based on observation on 12/16/09, the facility failed to keep medications belonging to 1 of 3 residents in their original container (Resident #2 -

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Omeprazole).

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